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ALERT

Section 111 Bulletin: Long-Term Implications of Medicare Reporting Requirements and Reimbursement Liabilities for Casualty Insurers

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Liability insurers are about to become much more familiar with the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers the Medicare program. CMS has had in its legal arsenal for almost 30 years the right to hold both Group Health Plans (GHPs) and liability insurers to their statutory obligation to pay the medical expenses of Medicare beneficiaries, rather than Medicare, when a policy issued by the GHP or insurer covers those costs. Under the Medicare Secondary Payer (MSP) Statute, CMS may seek recovery of its payments to medical providers if it learns an insurer had the obligation to pay those costs as the primary payer, regardless of whether that insurer has made payment to the provider or Medicare beneficiary.

To date, however, CMS has largely pursued GHPs, and not liability insurers, to recover Medicare payments. This may be due, at least in part, to the fact that CMS has lacked sufficient and timely information about tort claims filed by Medicare beneficiaries. Many liability insurers have not yet needed to address the inequities of the MSP program that are borne by insurers that do not stand in privity of contract with those whose medical costs they may be compelled to pay not once, but twice-once to the Medicare beneficiary tort claimant and then to Medicare when it seeks to recoup its payments. The roll out of the new Medicare reporting requirements for insurers, and the expected increase in Medicare demands for reimbursement from them, means that those insurers must implement rigorous procedures-not just for reporting, but for claims handling as well-or

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Section 111 Insurer Reporting and MSP Reimbursement

face potentially serious consequences.

A 2007 amendment to the MSP statute allows CMS to obtain claims data from liability insurers and imposes onerous reporting requirements. Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) requires liability, no-fault and workers' compensation insurers (including self-insured entities), as well as GHPs, to report to CMS their payments for bodily injuries suffered by or medical services provided to a Medicare beneficiary. 42 U.S.C. § 1395y(b)(8). Liability insurers are likely to face considerable difficulty complying with the new reporting requirements, which demand information about the Medicare beneficiary typically not in the insurer's possession. By contrast, GHPs have direct insurance relationships with the underlying claimants and may have been voluntarily and contractually reporting similar claims data to the federal government for years. To implement the new Section 111 reporting scheme, insurers must create the necessary IT infrastructure and claims processing work flow to gather the required data and report it to CMS in the required format. But the implications of this change go far beyond IT procedures.

The government seeks claims data in order to pursue recoveries of Medicare conditional payments. Under the MSP statute, Medicare generally has secondary liability for payment of a Medicare beneficiary's medical claims whenever a liability insurer has a contractual obligation to pay. *See* 42 U.S.C. § 1395y(b), Social Security Act § 1862(b)(2)(A); 42 C.F.R. Part 411. If Medicare erroneously makes a primary payment or a beneficiary receives primary payment from both Medicare and a liability insurer for the same injury, Medicare wants to pursue recovery of its conditional payment. Receiving claims data through Section 111 reporting will alert Medicare to opportunities to recover conditional payments made by Medicare from liability insurers that have an obligation under federal law to pay first. The federal deficit, the escalating costs of the Medicare program, and the effort to fund expansion of healthcare entitlements provide strong incentives for aggressive future government enforcement of the Section 111 requirements.

Here are a few examples of recurring questions centered around who qualifies as a responsible reporting entity (RRE) that affect many liability insurers.

- **Liability Pools:** CMS is using the following test to determine the entity that qualifies as the RRE for liability self-insurance pools - Entities self-insured in whole or in part with respect to liability may elect, where permitted by law, to join with other similarly situated entities in a self-insurance pool (*e.g.*, joint powers authority). If the self-insurance pool (1) is a separate legal entity (2) with full responsibility to resolve and pay claims using pool funds (3) without involvement of the participating entities, the self-insurance pool is the responsible reporting entity. But what qualifies as "involvement"? If all three characteristics are not applicable to the self-insurance pool, the participating self-insured entities are each responsible reporting entities.
- **Excess Liability Insurance Over Self-Insurance:** CMS guidance states that the key to determining whether Section 111 reporting is required by an excess insurer that makes a claims payment after the self-insured retention amount has been exhausted is whether the insurer makes payment directly to the injured claimant or whether payment is made to reimburse the self-insured entity that pays the claimant. According to the CMS USER GUIDE, excess insurers who pay claimants directly are RREs and must

report data on such claims to CMS. Alternatively, excess insurers who reimburse self-insured entities for claims paid above a retention amount are not RREs for any portion of the payment amount. In this situation, the self-insured entity must report for both itself and the excess insurer.

- **Excess Liability Insurance Over Primary Insurance:** To date, CMS has not provided specific guidance for this far more common excess liability situation. While it is possible that the rule of thumb described for excess insurance over self-insurance in the USER GUIDE applies to policyholders that are not self-insured entities, CMS has not issued any direct guidance on this issue.
- **Deductibles:** The concepts of self-insured retention and deductible are often used imprecisely and, at times, CMS appears to describe both kinds of arrangements as "deductibles."

  - Insured is the RRE: If the deductible or a lesser amount is paid by the insured to the claimant, then the insured is the RRE for purposes of the deductible. If the insured makes payment of both the deductible and any amount above the deductible and is reimbursed by the insurer, the insured is the RRE. Furthermore, if the insured chooses to pay a claimant directly and without recourse to any existing insurance, all payment regardless of whether the amount exceeds the deductible is considered self-insurance and the insured is the RRE.
  - Insurer is the RRE: If the insurer pays both the deductible amount and any amount above the deductible, it is the RRE. In this situation, the deductible amount and the amount over the deductible is being reported as a single payment, not as partially self-insured and partially insured amount. In addition, the total of the deductible paid and any amount paid above the deductible is used to determine whether any applicable reporting threshold is met.
  - Both Insured and Insurer are RREs: If the insured pays the deductible separately to the claimant and the insurer pays the amount above the deductible separately, then both the insured and the insurer are RREs for their respective payments.
- **Fronted Policies:** CMS has discussed the issue of fronted policies in public town hall conference calls, generally taking the position that where the insured pays all claims, the insured, rather than the insurer, is the RRE. It is not clear that CMS has considered all of the arrangements that might fall within the broad rubric of "fronting," including issues relating to captive insurance and reinsurance.
- **Mass Torts:** To date, CMS guidance has not clearly addressed what reporting will be required from RREs involved in mass torts litigation (or who serves as an RRE). These claims raise many Section 111 issues, including: (1) what is a mass tort; (2) how to determine whether Medicare beneficiaries are involved when individual claimant data may not be in the RRE's possession; (3) what efforts CMS may require from RREs to obtain beneficiary information not in their possession; and (4) what reporting, if any, is required of an insurer that makes no payments to individual claimants but instead resolves its coverage obligations to the insured by making a lump sum payment to the insured or plaintiff's attorney or by placing funds in escrow without allocation to any individual claimant's medical expenses. During the July 14, 2009 town hall teleconference, CMS announced that interested parties may advise CMS by

email of their desire to join the working group that CMS has formed to address these and other issues.

It is time to pay attention. Implementation deadlines for Section 111 reporting requirements are imminent:

- All claims that meet the CMS established thresholds that were resolved through a settlement, judgment, or award as of January 1, 2010 or claims for which the RRE has assumed ongoing responsibility for medicals as of or after July 1, 2009 are subject to the new reporting regime.
- The deadline for liability insurers to register on-line with CMS as Responsible Reporting Entities (RREs) is September 30, 2009.
- All RREs must begin reporting quarterly to CMS during the second quarter of 2010, by a date to be assigned by CMS.
- Testing of reporting procedures began at the beginning of July, 2009.

Liability insurers will be required to obtain and report extensive information, some of which is not likely to be available from traditional claims files. RREs must report to CMS under more than 100 data fields, including:

- Social Security Number or Medicare Health Insurance Claim Number for the injured Medicare beneficiary
- Plan insurance type
- Policyholder
- Attorney for claimant
- Date of Incident (DOI) (For an automobile collision or other accident, the DOI is the date of the accident. For claims involving exposure, the DOI is the date of first exposure.)
- Resolution (including how the claim was resolved and for what amount)

Some of the required information can be obtained only from the injured claimant who, perversely, appears to have no statutory obligation to provide such information to the insurer and perhaps an incentive not to do so.

Stiff penalties can result from a failure to report. Insurers that fail to report claims data in accordance with CMS guidance can be assessed civil monetary penalties of $1,000 for *each day* of noncompliance for *each individual* for whom they should have submitted information. The technical reporting procedures are complicated and will require significant time and money to implement. It is unclear when CMS will begin imposing penalties, and whether there will be circumstances that will mitigate penalties. Without mitigation, it would appear that a constitutional challenge to the penalty structure is likely.

CMS is unfamiliar with the business of liability insurers. As a result, CMS has struggled to adapt the prior GHP reporting system to the complex context of liability insurance. Changes in reporting requirements are sure to be made over time, and some are expected to be announced in a revised version of the Section 111 Non-GHP User Guide to be released reportedly as soon as the end of July. Wiley Rein attorneys will continue

to monitor CMS guidance, including the monthly CMS Town Hall teleconferences, and track policy decisions made by the agency.

If a liability insurer pays a liability settlement or judgment, it may incur a duplicative liability to Medicare if Medicare is unable to recover any conditional payments it may have made for medical services from the beneficiary or provider. Under MSP law, if Medicare also paid the beneficiary's medical costs, Medicare may seek to recover those sums from the liability insurer, *even if* the insurer has already paid the beneficiary or provider. Although Medicare should seek recovery first from beneficiaries (as well as their counsel or their providers), Medicare recovery from claimants who received payments of settlements or judgments from liability insurers is often difficult if Medicare is not invited into claims negotiation before payment.

Liability insurers may face conflicts between state law governing claim handling and their potential obligation to Medicare under MSP. An insurer that delays payment of a settlement or judgment pending an advance determination of the amount owed to Medicare may face allegations by the injured claimant or policyholder that it has not complied with state claim handling statutes or common law obligations, but an insurer that pays the claim without obtaining such a determination faces potential duplicative liability.

In addition to preparing to meet the new reporting requirements, liability insurers should take measures to protect their interests with respect to liability claims asserted by a Medicare beneficiary. Given that liability insurers, unlike GHPs, lack privity with the individuals whose medical costs they pay, the application of the MSP law to liability insurers raises many questions, including *inter alia*:

- To what extent can liability insurers protect themselves by providing advance notice of potential settlements to CMS and getting an advance determination of any obligation to reimburse Medicare?
- Is a liability insurer obligated to reimburse Medicare for payments Medicare makes for medical services incurred post settlement or judgment? For payments Medicare makes for services rendered before settlement or judgment but which Medicare pays post settlement or judgment?
- What mechanisms, if any, exist in underlying tort actions to seek judicial determination of any Medicare reimbursement liability?
- How does the three-year statute of limitations apply to Medicare reimbursement claims?
- Do the MSP statute and implementing regulations preempt state law regarding claim handling and prompt payment?
- Do the MSP statute and implementing regulations preempt the collateral source rule?
- Do state no-fault laws limit insurer discretion to use protective measures?
- What Constitutional constraints and defenses exist to protect liability insurers against duplicative payments for medical services provided to a Medicare beneficiary?

A discussion of these issues is beyond the scope of this alert, but they are issues that warrant insurer attention.

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Wiley Rein has formed a team to support insurers who are concerned about their claims reporting obligations and potential underlying liability to Medicare for medical costs. The team wishes to acknowledge the substantial contributions of Katherine McDonald, a clerk at the firm and law student at Georgetown University, to this and other MSP publications.